STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		15E594	B. WING		06/26/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹	2907 E	136TH ST	
	EY HEALTH CARE	CENTER		EL, IN 46033	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K010000					
	A Life Safety Co	ode Recertification and	K010000	Disclaimer : Preparation,	
		Survey was conducted by	11010000	Submission and Implemenation	n
		•		of this Plan of Correction does	
		e Department of Health in		constitute an admission of/ or	
	accordance with	42 CFR 483.70(a).		agreement with the findings of	of
	Survey Date: 06	6/26/13		this survey. McGivney Health- care reserves the right contest the survey findings	t to
	Facility Number	000545		through the informal dispute	
	Provider Number			resolution, formal appeal pro- ceedings or any administrative	v or
	AIM Number: 1			legal proceedings. The facilit	
	Anvi Number.	10020/330		offers its responses, credible	
	Curvayar Mark	Carabar Lifa Safaty		allegations of compliance, ar	d
		Caraher, Life Safety		plan of correction as part of	
	Code Specialist			ongoing efforts to provide qu	
				care. McGivney Healthcare C Center reserves the right to	are
	At this Life Safe	•		modify policies, procedures,	and
	McGivney Healt	th Care Center was found		quality improvement systems	
	not in compliance	ce with Requirements for		necessary to better meet the	
	Participation in 1	Medicaid, 42 CFR		needs of the residents and	
	Subpart 483.70(a), Life Safety from Fire		facility.	
	`	lition of the National Fire			
		ciation (NFPA) 101, Life			
		SC), Chapter 19, Existing			
		cupancies and 410 IAC			
	16.2.				
	TIL:				
	1	acility with a lower level			
		to be of Type V (111)			
	construction and	I fully sprinklered. The			
	facility has a fire	e alarm system with			
	smoke detection	in the corridors and in all			
	areas open to the	e corridor. The facility			
	_	etors hard wired to the fire			
	nus smoke detec	TOTO TIME WITHOUT TO THE THE			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000545

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15E594	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPL 06/26/	ETED
	ROVIDER OR SUPPLIER EY HEALTH CARE CENTER	2907 E	ADDRESS, CITY, STATE, ZIP (136TH ST EL, IN 46033	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	alarm system installed in all resident sleeping rooms. The facility has a capacity of 37 and had a census of 34 at the time of this visit.				
	All areas where residents have customary access were sprinklered. The facility has one detached storage buildings providing facility services which was not sprinklered.				
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/13.				
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 2 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594		LDING	ONSTRUCTION 01	(X3) DATE COMPL 06/26 /	ETED
	ROVIDER OR SUPPLIER		B. WIIV	STREET A 2907 E	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033	!	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K010020 SS=E	ventilation shafts, openings between construction having of at least one how in accordance with Based on observing facility failed to stair enclosure where accordance with deficient practices staff and visitors stairwell on the last of Findings included. Based on observing of Facilities and during a tour of the a.m. to 1:50 p.m. level stairwell do by a magnetic deand latch into the was manually retimes. The lower abuts the frame was from closing and frame. In additing door failed to coulatch into the doc alarm system was on 06/26/13. Based on 05/26/13. Based on 05/26/13. Based on 05/26/13.	or shafts, light and chutes, and other vertical in floors are enclosed with ing a fire resistance rating ur. An atrium may be used in 8.2.5.6. 19.3.1.1. In ation and interview, the ensure 1 of 2 doors in a ras self closing in Section 19.3.1.2. This is a could affect 8 residents, in the vicinity of the ower level.	K0	10020	1. The Lower Level Stairway door was repaired to close the way into frame and latch. All residents have the potentiabe affected by the deficient practice. 3. Doors will be checked Quarterly during FireDrills. Staff in-service on citation 07/12/2013. Results will be taken to QA x3 Months, and Quarterly thereafter until deemedunnecessary by the Medical Director and or ID Team. 5. DOC: 07/26/2013	2. Il to t ed 4.	07/26/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 3 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15E594	A. BUILDING	01	COMPLETED 06/26/2013
		100004	B. WING	ADDRESS STEEL ST. SO.	00/20/2013
NAME OF P	PROVIDER OR SUPPLIER	2		ADDRESS, CITY, STATE, ZIP CODE 136TH ST	
	EY HEALTH CARE		CARME	EL, IN 46033	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
1710		operty Management	1710		DATE
		ne lower level stairwell			
		se and latch into the door			
	frame.				
	3.1-19(b)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet Page 4 of 22

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION O1	(X3) DATE : COMPL	
ANDILAN	or correction	15E594	A. BUII		01	06/26/	
		100004	B. WIN	_		00/20/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MCGIVNI	EY HEALTH CARE	CENTER			136TH ST EL, IN 46033		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
K010029 SS=E	NFPA 101 LIFE SAFETY CO One hour fire rate hour fire-rated do automatic fire exti accordance with 8 protects hazardou approved automa system option is a separated from or resisting partitions self-closing and n protective plates to inches from the bear permitted. 19.3 Based on observations facility failed to serving hazardou heater rooms was latch into the door practice could after and visitors in the room by Room 1 Findings include Based on observations and Producing a tour of touring a tour of touring a tour of touring a fired furnace provided with a self-conservation, the Property Management of the servation of the servation of the Property Management of the servation of the Property Management of the servation of the	DDE STANDARD ad construction (with 3/4 ors) or an approved inguishing system in B.4.1 and/or 19.3.5.4 us areas. When the atic fire extinguishing used, the areas are ther spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 ottom of the door are b.2.1 ation and interview, the ensure 1 of 9 doors as areas such as fuel fired as self closing and would by frame. This deficient are vicinity of the furnace by the facility from 11:50 and on 06/26/13, the furnace by the facility from 11:50 and the entry door is not and the entry door is not and the time of birector of Facilities and bement acknowledged the	K0)	10029	1. Door assessed by Regional Maintenance Director and repaired with replacement spri loaded door hinges to replace broken spring loaded hinges. 06/26/2013 All residents/ visitors have the potential to be affected by deficient practice. 3. Door will checked	ng 2. this I be	DATE 07/26/2013
	atorementioned l	hazardous area is not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 5 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15E594	(X2) MULTIPLE CO A. BUILDING B. WING	01	COM	TE SURVEY MPLETED 26/2013
	PROVIDER OR SUPPLIER EY HEALTH CARE CENTER	2907 E	ADDRESS, CITY, STATE, ZI 136TH ST EL, IN 46033	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TI DEFICIENCY	N SHOULD BE	(X5) COMPLETION DATE
	provided with a self closing device on the entry door to the room.				
	3.1-19(b)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 6 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	01	COMPL	ETED
		15E594	B. WIN			06/26/	2013
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2907 E	136TH ST		
	EY HEALTH CARE	CENTER		CARME	EL, IN 46033		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
K010046 SS=C	LIFE SAFETY CO	ODE STANDARD					
33-0		ng of at least 1½ hour					
		ed in accordance with 7.9.					
	19.2.9.1.						
	Based on record	review, observation and	K01	10046	1. Monthly Functional Testing		07/26/2013
	interview; the fac	cility failed to document			Form was updated to reflect a second monthly test and 90	30	
	testing of emerge	ency lighting in			minute annual test.		
	accordance with	LSC 7.9 for 16 of 16			06/28/2013 2. All residents /		
	battery powered	lights for 12 months.			vistors have the potential to be		
	LSC 7.9.3 Period	dic Testing of Emergency			affected by this deficient practi	ce.	
	Lighting Equipm	nent requires a functional			Maintenance will perform check monthly to ensure 3	20	
	test to be conduc	ted at 30 day intervals for			Second Monthly	50	
	not less than 30 s	seconds. Equipment shall			Test is completed,		
	be fully operation	nal for the duration of the			including using updated form v	vith	
	test. Written rec	ords of visual inspections			correct language of 30	20	
	and tests shall be	kept by the owner for			second monthly test and 9 minute annual test. Executive	90	
		e authority having			Director will request form		
		s deficient practice could			randomly to check for		
	· ·	ts staff and visitors.			compliance. Staff in-service	ced	
					on citation 07/12/2013. 4.		
	Findings include				Results will be taken to QA monthly x 6 Months and Quart	erly	
		•			thereafter or until Medical	O.I.y	
	Based on review	of "Monthly Testing Fire			Director / IDT Team deems		
		It Light System" for 2012			unnecessary. 5. DOC:		
	•	Light/Extinguisher			07/26/2013		
	•	2013" with the Executive					
		Director of Facilities and					
		ement during record					
		a.m. to 11:50 a.m. on					
		entation of functional					
	,	intervals for 30 seconds					
		ittery powered emergency					
	-	ity for the most recent					
	twelve month pe	riod was not available for					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet Page 7 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION NUMBER: 15E594	A. BUILDING B. WING	COMPLETED 06/26/2013
	ROVIDER OR SUPPLIER EY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST CARMEL, IN 46033	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDERS PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	OBE COMPLETION
	review. Based on interview at the time of record review, the Director of Facilities and Property Management stated the aforementioned documentation is a monthly record of functional testing, but not for thirty seconds and acknowledged functional testing documentation at 30 day intervals for 30 seconds for each of 16 battery powered emergency lights in the facility for the most recent twelve month period was not available for review. Based on observations with the Director of Facilities and Property Management during a tour of the facility from 11:50 a.m. to 1:50 p.m. on 06/26/13, each of the 16 battery powered emergency lights in the facility illuminated when their respective test button was pushed. 3.1-19(b)		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet Page 8 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	01	COMPL	ETED
		15E594	B. WIN			06/26/	2013
MCGIVN	ROVIDER OR SUPPLIER	CENTER	•	2907 E CARME	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010050 SS=C	under varying cor on each shift. The procedures and is of established rouplanning and conconly to competent to exercise leade conducted between announcement maudible alarms. Based on record facility failed to conducted on the quarters. This deaffect all resident Findings include Based on review Record document Executive Direct from 9:40 a.m. to documentation for the fire drill aforementioned in the fire drill aforementioned i	d at unexpected times nditions, at least quarterly e staff is familiar with a aware that drills are part utine. Responsibility for ducting drills is assigned t persons who are qualified rship. Where drills are en 9 PM and 6 AM a coded may be used instead of 19.7.1.2 review and interview, the document fire drills e second shift for 1 of 4 efficient practice could tts, staff and visitors.	KO	10050	1. The fire drill on 8/30/2012 w completed, time cannot be determined since Executive Director and Maintenance Stare no longer employed. 2. S Residents, and Visitors have the potential to be affected on this deficient practice. 3. Fire Drills will be conducted on each shift at least quarterly. Execu Director will review Fire Drill Documentation to ensure shift and time are recorded. Regional Maintenance will revidocumentation upon visits to facility. Staff in- serviced on citation 07/12/2013 4. Result to QA x 6 months and Quarter thereafter or until deemed unnecessary by the Medical Director and or IDT Team. 5. DOC: 07/26/2013	aff taff, e ch tive	07/26/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 9 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15E594	(X2) MULTIPLE CO A. BUILDING B. WING	01	— COM 06/2	TE SURVEY SPLETED 26/2013
	PROVIDER OR SUPPLIER EY HEALTH CARE CENTER	2907 E	ADDRESS, CITY, STATE, ZIP C 136TH ST EL, IN 46033	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	aforementioned fire drill was conducted was not available for review.				
	3.1-19(b)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 10 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLL IDENTIFICATION NUMBER: 15E594			A. BUILI	DING	NSTRUCTION 01	(X3) DATE S COMPL 06/26/	ETED
NAME OF P	ROVIDER OR SUPPLIER		B. WING	STREET A 2907 E	ADDRESS, CITY, STATE, ZIP CODE	00,20	
MCGIVNI	EY HEALTH CARE	CENTER		CARME	EL, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K010062 SS=E	continuously mair condition and are periodically. 19 NFPA 25, 9.7.5 Based on observation facility failed to in the oxygen storoom which had requires all autor shall be inspected in accordance with for the Inspection Maintenance of Protection Systemedition, 2-2.1.1 r shall be replaced corroded, damage improper oriental practice could after and visitors in the storage and transfer Findings included Based on observation for the Inspection Systemedition, 2-2.1.1 r shall be replaced corroded, damage improper oriental practice could after and visitors in the storage and transfer included Based on observation of the Inspection of the Inspect	tic sprinkler systems are ntained in reliable operating inspected and tested .7.6, 4.6.12, NFPA 13, ation and interview, the replace 1 of 2 sprinklers orage and transfilling been painted. LSC 9.7.5 matic sprinkler systems d, tested and maintained th NFPA 25, Standard n, Testing, and Water-Based Fire ms. NFPA 25, 1998 equires any sprinkler which is painted, ed, loaded, or in the tion. This deficient fect 24 residents, staff e vicinity of the oxygen filling room.	K010	0062	1. Removed drywall componet from Sprinkler Head and Cleaned. 7/8/2013 2. All residents, Vistors and Staff hat the potential to be affected this deficient practice. 3. Weekly rounds will be conduct by Designee to check for all for foreign material on sprinkle Regional Maintenance Direct to check sprinklers randomly during facility visits Any sprinkler found to be questionable, facility will contact outside professionals to inspect and repair as needed. Staff in-serviced on citation 07/13/2013 4. Results QA x 6 months and Quarterly thereafter until Medical Directo IDT deem unnecessary. 5. Design 10 of	ve by red ny ers. or .	07/26/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet Page 11 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 15E594	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPL 06/26	ETED
	PROVIDER OR SUPPLIER EY HEALTH CARE CENTER	2907 E	ADDRESS, CITY, STATE, ZIP 136TH ST EL, IN 46033	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	time of observation, the Director of Facilities and Property Management acknowledged the aforementioned automatic sprinkler in the oxygen storage and transfilling room had paint on the deflector. 3.1-19(b)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 12 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	FICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		01	COMPLETED	
		15E594	B. WIN			06/26/2	2013
	PROVIDER OR SUPPLIER		.	2907 E	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010076 SS=E	areas are protector NFPA 99, Standar Facilities. (a) Oxygen storag 3,000 cu.ft. are enseparation. (b) Locations for sthan 3,000 cu.ft. and NFPA 99 4.3.1.1. 1. Based on obsethe facility failed storage locations cubic feet was seen of a facility where examined, or treaffire barrier of 1 h construction and distance of at lead combustible maters and a system. This default is system. This default affect 24 resident the vicinity of the transfilling room.	age and administration and in accordance with ards for Health Care ge locations of greater than inclosed by a one-hour supply systems of greater are vented to the outside. 2, 19.3.2.4 ervation and interview, I to ensure 1 of 1 oxygen are of greater than 3000 apparated from any portion are in residents are housed, atted by a separation of a mour fire resistive separated by a minimum ast five feet from are in the serials. NFPA 99, unires oxidizing gases shall be separated from a minimum distance of quired storage location is automatic sprinkler ficient practice could ts, staff and visitors in e oxygen storage and	K01	10076	1. Liquid Oxygen Removed. Relocated Liquid Oxygen to a outside storage area in a flameable cabinet with a locking door and proper signage. 2. A residents, vistors, and staff have the potential to be affected by this deficient practice. 3. Nursi Staff will check outside flameable cabinet after filling of portable tanks. Upon hire of maintenance oxygen / cabinet will check weekly during walking rounds. Executive Director will check Medication Room Quarterly to ensure no Oxygen Unit is stored. Oxygivendor will be instructed to leave no Oxygen in Medicicat Room and to place into new cabinet outside on cement patio. Facility will maintain Oxygen Cylinders to 3,000 cubic feet or less. Regio Maintenance Director will check for compliance upon visits to facility. Staff inserviced on cita 07/12/20134. Results to QA	ng All ve y ng 02 ng n gen ion	07/26/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 13 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 06/26/2013		
		102004	B. WIN			00/20/	2010
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2907 E 136TH ST				
MCGIVN	EY HEALTH CARE	CENTER			EL, IN 46033		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISE INDUSTRIAL TRANSPORTATIONS		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	(X5) COMPLETION
TAG	of Facilities and during a tour of tam. to 1:50 p.m. door to the oxygeroom by the Nurslabel stating it has resistance rating. oxygen storage of quarters full was room and two playwere on the floor and transfilling reliquid oxygen storage of door had less than a one has and acknowledge transfilling room separation of at least the resistance rating oxygen storage at less than a one has and acknowledge transfilling room separation of at least the resistive construction of Facilia Management ack materials were befeet from a liquid capacity greater to 3.1-19(b)	ew at the time of the Director of Facilities nagement stated the entry in a 45 minute fire and the ceiling of the nd transfilling room had our fire resistance rating, and the oxygen storage and did not provide least one hour fire and Property showledged combustible leing stored less than five than 3000 cubic feet.		TAG	monthly x6 months and Quarte thereafter oruntil deemed unnecessary by Medical Dire and or IDT Team. 5. DOC: 07/26/2013	erly	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet Page 14 of 22

	OF CORRECTION OF CORRECTION 15E594 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/26/2013
	PROVIDER OR SUPPLIER JEY HEALTH CARE CENTER	STREET A 2907 E	ADDRESS, CITY, STATE, ZIP CODE 136TH ST EL, IN 46033	1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	electrical wall fixtures in the oxygen storage and transfilling room was located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observations with the Director of Facilities and Property Management during a tour of the facility from 11:50 a.m. to 1:50 p.m. on 06/26/13, two refrigerators were plugged into one electrical outlet which was located on the wall 12 inches (1 foot) above the floor and one light switch was located on the wall 54 inches (4 feet, 6 inches) above the floor. One liquid oxygen storage container which was three quarters full was observed stored in the room. Based on interview at the time of the observations, the Director of Facilities and Property Management acknowledged each of the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 15 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 15E594	(X2) MU A. BUII B. WIN	LDING	01	COMPI 06/26	
	PROVIDER OR SUPPLIER EY HEALTH CARE CENTER	•	2907 E	ADDRESS, CITY, STATE, ZIP C 136TH ST EL, IN 46033	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	aforementioned electrical wall fixtures were located on the wall less than five feet above the floor of the oxygen storage and transfilling room.	;				
	3.1-19(b)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 16 of 22

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	E SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING 01 COM			ETED
		15E594	B. WING			06/26/	2013
NAME OF B	DOLUDED OD GUDDU IED				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2907 E	136TH ST		
MCGIVNI	EY HEALTH CARE	CENTER		CARME	EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010143 SS=E	NFPA 101 LIFE SAFETY CO	ODE STANDARD					
33-E	Transferring of ox						
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
		n any portion of a facility					
		are housed, examined, or					
	1-hour fire-resistiv	ration of a fire barrier of					
	1-110ul III-lesisti	ve construction,					
	(b) in an area tha	t is mechanically ventilated,					
		nas ceramic or concrete					
	flooring; and						
	(c) in an area pos	sted with signs indicating					
		s occurring, and that					
		mediate area is not					
	•	rdance with NFPA 99 and					
	the Compressed 8.6.2.5.2	Gas Association.					
		ervation and interview,	KU1	0143	1.1. Removed Liquid Oxygen		07/26/2013
		I to ensure 1 of 1 liquid	Koi	.0173	Relocated Liquid Oxygen to a		07/20/2013
	•	reas where transferring			outside storage area in a		
		place was separated from			flameable cabinet with a locki	•	
		facility wherein residents			door and proper signage.2. A residents, vistors and staff have		
					the potential to be affected by		
		nined, or treated by a fre barrier of 1 hour fire			this deficient practice. 3. Nursir		
	•	ction. This deficient			Staff will check outside		
					flameable cabinet after filling 0)2	
	•	fect 24 residents, staff			portable tanks. Upon hire of maintenance oxygen /		
		e vicinity of the oxygen			cabinet will check weekly		
	storage and trans	silling room.			during walking rounds.		
	Diadio and 1 1				Executive Director will check		
	Findings include				Medication Room Quarterly to ensure no Oxygen Unit is		
	D 1 1	allows that D'			stored. Oxygen Vendor will be	9	
		ations with the Director			instructed to leave no Oxygen		
		Property Management,			in Medicication Room and		
		nd Staff Nurse # 2 during			to place into new cabinet		
		lity from 11:50 a.m. to			outside on cement patio. Fac		
	1:50 p.m. on 06/2	26/13, the entry door to	1		will maintain Oxygen Cylinder	ร เบ	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet Page 17 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15E594	A. BUILDING	01	COMPLETED 06/26/2013	
		102394	B. WING	ADDRESS SITES STATE STATE SORE	00/20/2013	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE 136TH ST		
MCGIVN	EY HEALTH CARE	CENTER		EL, IN 46033		
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	be 3,000 cubic feet or	DATE	
	, , ,	age and transfilling room tation had an affixed		less. Regional Maintenance		
	*	ad a 20 minute fire		Director will check for		
	_	g. In addition, one liquid		compliance upon visits to facility. Staff inserviced on cita	ation	
		container which was three		07/12/20134. Results to QA	20011	
		s observed stored in the		monthly x6 months and Quart	erly	
	room. Based on	interview at the time of		thereafter oruntil deemed unnecessary by Medical Dire	ector	
	the observations	, the Director of Facilities		and 5. DOC: 07/26/2013		
		anagement stated the				
	ceiling of the oxygen storage and transfilling room had less than a one hour					
		ating and the door had less				
	than a 45 minute	•				
	_	he oxygen storage and n did not provide				
		least one hour fire				
	•	action. Based on				
		time of observation, Staff				
		taff Nurse # 2 both stated				
	oxygen transfill	ing does occur in the				
	room.					
	2.1.10(1.)					
	3.1-19(b)					
	2. Based on obs	servation and interview,				
	the facility faile	d to ensure 2 of 2				
	electrical wall fi	xtures in the oxygen				
	_	sfilling room were located				
		above the floor. NFPA				
		n Standard for Health				
		Section 8-3.1.11.2(f)				
	•	al fixtures in oxygen				
	storage location					
	4-3.1.1.2(a)11(d) which requires ordinary				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 18 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	01	(X3) DATE COMPL	
THE TERM	or condition	15E594		LDING		06/26/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/	
NAME OF P	PROVIDER OR SUPPLIER				136TH ST		
MCGIVN	EY HEALTH CARE	CENTER			EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		xtures in supply rooms		TAG			DATE
		in fixed locations not					
		et above the floor to avoid					
		This deficient practice					
		esidents, staff and visitors					
		the oxygen storage and					
	transfilling room						
	<i>S</i> - 3						
	Findings include	:					
	_						
	Based on observ	ations with the Director					
	of Facilities and	Property Management,					
	Staff Nurse # 1 a	and Staff Nurse # 2, two					
	refrigerators wer	e plugged into one					
	electrical outlet	which was located on the					
	· ·	foot) above the floor					
		itch was located on the					
	,	I feet, 6 inches) above the					
	floor. One liquid						
		was three quarters full					
		ored in the room. Based					
	on interview at the						
	· · · · · · · · · · · · · · · · · · ·	e Director of Facilities					
		nagement acknowledged					
		mentioned electrical wall atted on the wall less than					
		he floor of the oxygen					
		sfilling room. Based on					
	_	time of observation, Staff					
		aff Nurse # 2 both stated					
		ng does occur in the					
	room.	ing does occur in the					
	100111.						
	3.1-19(b)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 19 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E594	(X2) MULTIPLE CO A. BUILDING B. WING	01	COM	e survey pleted 6/2013
NAME OF P	ROVIDER OR SUPPLIER			address, city, state, zii 136TH ST	P CODE	
MCGIVNI	EY HEALTH CARE	CENTER		EL, IN 46033		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 20 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	PROVIDER/SUPPLIER/CLIA (X2) NTIFICATION NUMBER:		ULTIPLE CC	ONSTRUCTION O1	(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	15E594	A. BUII		01	06/26/	
		102004	B. WIN			00/20/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 136TH ST		
MCGIVN	EY HEALTH CARE	CENTER			EL, IN 46033		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
K010144 SS=F	NFPA 101 LIFE SAFETY CO Generators are in exercised under le month in accordance 3.4.4.1. Based on record facility failed to of test for the emerge conducted for 1 co of the three follow operating temper less than 30% of Supply (EPS) national which maintains gas temperatures manufacturer. Co 99 requires mont serving the emerge be in accordance Chapter 6-4.2 of generator sets in service to be exempled to the service to the service to the exempled to the service to the service to the service to the exempled to the service to the exempled to the service to	DDE STANDARD spected weekly and bad for 30 minutes per nece with NFPA 99. review and interview, the ensure a monthly load gency generator was of 12 months using one wing methods: under rature conditions, at not the Emergency Power meplate rating, or loading the minimum exhaust as recommended by the hapter 3-4.4.1.1 of NFPA hly testing of generators gency electrical system to with NFPA 110. NFPA 110 requires Level 1 and Level 2 reised at least once inimum of 30 minutes, following methods: ag temperature conditions in 30 percent of the EPS maintains the minimum peratures as with manufacturer. e of day for required ecided by the owner,	KOI	10144	1. The generator is programed run, load, and exercise trans switch every other Thursday a 1pm for 30 minute for a load test duration during a transition period. 2. All residents / visito and staff have the potential traffected by this deficient pract 3. Maintenance will obtain last date of last generator run and make a schedule to witner program function. Data will be record into Life SafetyBook Regional Maintenance Directorwill review data upon facility visits to ensure compliance of life safety code. Preventive Maintenance Program will be overseen by Regional Maintenance Director Any concerns noted will be brought to the Executive Director. 4. Results to QA x6 months, Quarterly thereafter until deemed unnecessary by Medical Director and or IDT Team. 5. DOC: 07/26/2013	ofer t t nal rs b be tice. ss ll ty ce	07/26/2013
ı	deficient practice	e could affect all					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 21 of 22

PRINTED: 07/22/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	01	COMP	LETED
	15E594	B. WING		06/26	/2013
	PROVIDER OR SUPPLIER IEY HEALTH CARE CENTER	2907 E	address, city, state, zif 136TH ST EL, IN 46033	P CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	residents, staff and visitors.				
	Findings include:				
	Based on review of "MHCC Emergency Generator-Monthly Test Log" for 2012 and 2013 and Evapar's "Maintenance Order" documentation dated 05/16/13 with the Executive Director and the Director of Facilities and Property Management during record review from 9:40 a.m. to 11:50 a.m. on 06/26/13, documentation of a monthly load test for May 2013 was not available for review. The aforementioned documentation from Evapar stated "No transfer test performed" and the "MHCC Emergency Generator-Monthly Test Log" had no documentation for a monthly load test in May 2013. Based on interview at the time of record review, the Director of Facilities and Property Management stated Evapar was supposed to conduct the May 2013 monthly load test for the facility but acknowledged documentation of a May 2013 monthly load test was not available for review. 3.1-19(b)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GRQD21

Facility ID: 000545

If continuation sheet

Page 22 of 22